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United States House Committee on Oversight & Government Reform
Subcommittee on Federal Workforce, U.S. Postal Service & the Census
"The Federal Employees Health Benefit Program: Is It a Good Value for Federal Employees?"
Testimony of Thomas Choate
UntiedHealth Group Incorporated

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Thank you, Chairman Farenthold and Ranking Member Lynch for holding this important and timely hearing. I appreciate the opportunity to share with you UnitedHealth Group's perspective on how increased competition can bring more health care choices, higher quality and better value to the Federal Employee Health Benefits Program (FEHBP). Reform of the FEHBP would better serve the program's sponsor, its beneficiaries and the American taxpayers.

My name is Tom Choate and I am the Chief Growth Officer for UnitedHealthcare, a business segment of UnitedHealth Group Incorporated (hereinafter "UnitedHealth Group"), a diversified health and well-being company based in Minnetonka, Minnesota. I am here testifying on behalf of UnitedHealth Group. At UnitedHealth Group, I have been an integral part of our existing FEHBP business and have worked for many years with the Office of Personnel Management (OPM) and our dedicated FEHBP team.

UnitedHealth Group serves more than 80 million people in all 50 states and worldwide through our health benefits and health services businesses. We have the unique ability to participate in all aspects of the health care delivery system and apply lessons learned at full-scale in the marketplace. As a result, we view health care delivery and benefit design through multiple lenses. Our findings are informed by our experience with:

- Direct relationships with 770,000 health professionals, 5,000 hospitals, 154,000 dentists, 67,000 pharmacies, 900 labs, 400 life science organizations, 300 commercial insurance companies and health plans, and 300 government agencies at the Federal, State and local levels;

- 27,000 physicians, nurses, and clinical practitioners in our workforce;

- Managing more than $300 billion in health care spending annually;

- Processing 82 billion transactions a year, including 750 million transactions through our Web portals and mobility devices; and

- Managing more than 24 million Personal Health Records.

We tailor health benefits, clinical programs and customer service for 3.8 million Medicaid beneficiaries, 9 million Medicare recipients, and more than 26 million Americans through their employer sponsored or individual plans. We have the privilege of managing the health care services for 2.7 million active duty and retired military service members and their families in the 21-State TRICARE West Region.

We strive to foster a health system that is more connected, better informed, and better aligned in its objectives and incentives to continuously improve the effectiveness, quality, and patient focus of the health system. Our approach leverages health data and analytics, technology, shared accountability, cost saving measures, and collaboration among providers, payers and patients across the health care delivery spectrum.

One thing we know for certain: It is essential for any employer who sponsors health plans to be able to offer a choice of affordable, high-quality benefit options to its employees, while also ensuring the employer gets the best value for its resources. This is as true of the Federal Government's options for federal employees, their families and retirees as it is of any employer, including the private sector, and state and local governments.

However, unlike other employers, including the private sector and state and local governments, the Office of Personnel Management needs Congress to act to update the existing statute that governs the Federal Employee Health Benefits Program to enable competition, modernize this outdated health benefits program, and provide its beneficiaries with more choice and coverage options comparable to today's broader marketplace offerings. This kind of reform, importantly, will also confront the ongoing challenges of rising health care costs.

FEHBP beneficiaries deserve this same modernized health care experience, and the Federal Government, like any employer, should benefit from a healthier, more engaged population, better health care value, and lower costs.

History and Background

The Federal Employees Health Benefits Program (FEHBP) is the largest employer-sponsored health insurance program in the United States. The $47 billion Program protects the health of nearly 8 million Federal employees, retirees and their families, including the Congress, the Judiciary, and the US Postal Service. You, your staff, and your families may well be beneficiaries of the program; certainly, many of your constituents are.

The 54-year-old statutory structure of the Program does not reflect the current health care marketplace of today and limits OPM's ability to introduce new health plan choices.

As a result, a growing lack of competition and consumer choice threatens the sustainability of the Program, a problem that OPM has recognized. Without action, this erosion of competition and choice will continue.

However, a simple statutory change authorizing greater health plan participation in the Program will help increase competition, choice and value in the Program.

Competition: A Founding Principle of the FEHBP, in Jeopardy

The premise underlying the FEHBP from its inception in 1959 is that competition among health plans results in lower prices and better value for the Federal Government and Program beneficiaries. A June, 2012 Health Affairs article entitled *"Federal Employees Health Program Experiences Lack Of Competition In Some Areas, Raising Cost Concerns For Exchange Plans,"* demonstrated that in areas of strong FEHBP health plan competitiveness, premiums were more than 10 percent lower compared to areas of low competition.

However, the statute establishing the FEHBP lacks the flexibility to maintain competitiveness and adjust to current and future changes in the employer-sponsored health insurance marketplace. Created during the early years of employer-sponsored health insurance, the law specifically authorized participation by two Government-wide plans, a small number of Employee Organization Plans (largely grandfathered into the Program), and a number of Health Maintenance Organizations serving limited geographic areas.

For nearly three decades, that legislative specificity worked reasonably well. Two Government-wide plans were available, and nearly 400 plans participated in the Program. Competition for participants among many choices was robust, benefits were comprehensive, and plans continually strengthened benefit packages, customer service and administration to attract new participants.

But since the late 1980s, competition and choice in the Program have dramatically decreased. Aetna, one of the two Government-wide plans, left the Program in 1989. More than a dozen of the grandfathered Employee Organization Plans left the Program as well, and the number of participating Health Maintenance Organizations has dropped nearly 50 percent. Incrementally over succeeding years, choices have become fewer and participation in the one remaining Government-wide plan has grown substantially.

In addition to substantially fewer health plans in the Program, these trends are dramatically illustrated by the distribution of individual participants in the program.

Since 1995, the single government-wide plan has more than doubled its market share, from 30 percent of federal workers to more than 60 percent. The next largest plan has 7 percent of the market. That is clearly not a market in which real competition exists, a fact which OPM itself acknowledged in a White Paper it released last year that concluded "the competitive environment is not as robust as it should be."

Without Congress acting and granting OPM the authority to facilitate and enable the entry of new health plan types - which already exist in the broader health insurance marketplace across the United States - into the Program, these plan departures have created a situation where competition and choice in the Program today is largely an illusion. Without action to reinvigorate the competitive nature of the FEHBP, this situation will only worsen in the coming years. As the American health care marketplace continues to modernize, evolve and best serve the health care needs of employers and employees, we should ensure that the FEHBP is equally equipped with the tools and capabilities necessary to achieve these same modern, innovative and effective health care approaches.

Declining Competition Affects Health Care Value, Outcomes, Choice and Cost

Incremental in its effects, the current trend poses undesirable consequences, both now and for the future:

- **Affordability is at risk**. Between 1995 and 2010, 800,000 participants left the Program altogether. While a number of factors can influence enrollment, many can no longer afford health coverage. As participation becomes concentrated in a single insurer, affordability becomes an even more acute issue.

- **Innovation is at risk**. With little competition to spur improvement, health plans have fewer incentives and little capacity to innovate and provide better quality.

- **Individuals face disruption at work and at home**. When their plans leave the FEHBP, beneficiaries often have to choose new doctors and health care facilities, a problematic issue particularly in rural areas. Continuity of care issues present themselves, especially for individuals with chronic illnesses. In addition to its individual effects, disruption also means lower productivity and less commitment in the workplace.

- **Government costs increase**. The Federal Government pays an average of 72% of the premium. This year, the Government's share of the cost for the Program is almost $34 billion – an amount that in this age of budget restraint and fiscal challenges, the Government must find ways to manage.

Why Competition in the FEHBP Continues to Erode

As the administrator of the Program, OPM has recognized these trends and attempted to counteract them. OPM repeatedly invites new HMOs to submit applications for participation, with limited success. Several years ago, the agency unsuccessfully sought a new insurer to replace Aetna as the Government-wide Indemnity Benefit Plan. These and other initiatives by the agency to enhance competition have been helpful, but restrictions in current law limit their effectiveness.

That's because the law governing the FEHBP is far too prescriptive in nature when it describes the types of health plans which may participate in the Program. Current law, as it was enacted in 1959, only authorizes:

- **2 Government-wide Health Plans** - the Service Benefit Plan, which is administered by Blue Cross/Blue Shield, and the Indemnity Benefit Plan, which Aetna administered until its departure from the FEHBP in 1989.

- **Employee Organization Plans** - Only nine of these plans exist today, four of which limit membership to certain classes of participants. This category includes a finite list of organizations. No new employee organization plans may be accepted into the FEHBP.

- **Comprehensive Health Plans** - Now commonly referred to as Health Maintenance Organizations, these plans serve limited geographic areas, largely metropolitan areas in the United States.

For all practical purposes, the only way for an insurer to gain entry to the FEHBP today is in one of two ways. The first is to apply as the Government-wide Indemnity Benefit Plan. That course of action poses substantial insurer risk in today's market, effectively precluding insurer participation. Since one plan currently enjoys more than 60 percent of the market, the new plan would have to undertake an enormous educational and communications effort to move from zero membership to a subscriber base sufficient to recover its initial investment and ongoing operational costs. Furthermore, any new plan would be hampered by a crucial lack of transparency for all carriers except the plan with more than 60 percent market share. That dominant plan has a clear line of sight to its next year's enrollee premium rate contributions since the government contribution is based upon a weighted average of all carrier rates – and that plan accounts for more than 60% of that weight. That means the dominant plan can essentially set its competitive position using this knowledge and its reserve position.

Creating a benefit package available in all 50 states with a competitive premium in the current FEHBP environment would impose a substantial risk for any new plans, with no assurance of a return on investment for a number of years.

The second option is to apply as a Comprehensive Health Plan serving a limited geographic area. While that is possible for some insurers, it does not match up well with the business models of an increasingly large number of innovative insurers in the marketplace today, offering products which represent best practices among large employers, who could provide the Federal Government with the best combination of benefits and value. As OPM notes in its own analysis of the program, "the health insurance market includes other plan types that OPM is precluded from contracting with."

Solution: Restoring Competition to the FEHBP

The President's FY 2014 Budget Proposal recommends action by the Congress on a number of reforms in the FEHBP, including a proposal that would overcome restrictions on health plan participation in the Program, by adding a provision to the existing statute enabling OPM to receive and consider applications from new health plans that offer comprehensive medical benefits.

Benefits of Increased Competition

Enactment of this provision would be a significant step in enhancing the Program's competitiveness, both now and in the future. It would establish a level playing field, providing no advantage to any insurer or group of insurers. It would merely update and modernize the existing FEHBP statute to reflect the realities of the modern health care system, opening the door to choice, competition and value in the Program and removing artificial and outdated limitations on OPM's ability to accept new health care plans. Plans would still be required to meet all of OPM's existing requirements for participation, and OPM would retain the administrative and regulatory authority to deny or refuse entry to plans that do not meet acceptable standards. Here are some examples of the new types of plans which could apply for participation:

- A Preferred Provider Organization that operates in a single State, region, or nationally;

- A health insurance plan whose territory is confined to a particular region of the United States;

- An Exclusive Provider Organization that offers insurance in a single metropolitan area; and

- A health insurance plan that specializes in the provision of healthcare outside of the United States.

If Congress passes legislation consistent with this proposal, a broad range of potential benefits would accrue to everyone who has a stake in the success of the Federal Employees Health Benefits Program. For instance:

- More than 8 million Federal employees, retirees and family members would benefit from increased plan participation. Health plan choices would likely increase, resulting in quality health care at a competitive price. As previously mentioned, a June, 2012 Health Affairs article demonstrated that in areas of strong FEHBP competitiveness, premiums were more than 10 percent lower compared to areas of low competition. **Crucially, the article also concluded that real competition in the Program only exists in about 15 percent of the country, meaning that in 85 percent of the country, Program beneficiaries – and the Federal Government – are paying more than they should because competition doesn't exist in any meaningful way**;

- Since a variety of new health insurers would be able to enter the Program, many with innovative health delivery mechanisms focused on the quality of individual care and health outcomes, the FEHBP would reap the benefits of innovation and modernization in the larger health care marketplace; and

- OPM's role in benefit design and premium negotiations would be strengthened as a consequence of increased competition for participants among a larger group of health insurers.

What a Modernized FEHBP Would Look Like

A modern FEHBP rooted in competition and value would encourage participating insurers to provide beneficiaries the latest health care advancements and innovations, driving better health outcomes and increasing affordability. These would include:

- Flexible, creative plan offerings that encourage consumer engagement and empowerment;

- Transparency tools that give consumers the information and resources they need to make personally appropriate health care decisions, such as up-to-date, accurate cost estimates for specific services provided by doctors and hospitals;

- Powerful data analytics to help the Government evaluate plan performance, and identify specific opportunities for future cost savings through fully-integrated beneficiary data;

- Tailored programs to improve the health of beneficiaries with chronic, rare, or complex diseases; and

- Modern network-based offerings at a large scale that enhance care coordination, improve health outcomes, and reward providers for outcomes, not volume.

Much has changed since 1959. We've moved from typewriters to lap tops; from rotary dial phones to smart phones; from 45s to iTunes. The driving force behind such innovation has been competition. Innovation and competition have revolutionized the way we live, including the way many Americans consume health care. It's time to update that 1959 law, so federal employees and the Federal Government can also benefit from innovation and competition in the health care marketplace.

After all, one thing hasn't changed since 1959: The simple economic principle that customers and consumers benefit from increased competition.

Thank you for the opportunity to testify this morning, for your leadership on this Committee and for your ongoing commitment to and interest in federal workforce issues.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Thomas C. Choate

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2009. Include the source and amount of each grant or contract.

None

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

UnitedHealth Group Incorporated

I am Chief Growth Officer at UnitedHealth Group Incorporated.

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2009, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

None. (UnitedHealth Group Incorporated, on whose behalf I am testifying, receives no Federal grants and does not currently hold any Federal contracts. I am not representing, or responding on behalf of, any of UnitedHealth Group's operating subsidiaries, many of which do hold Federal contracts.)

I certify that the above information is true and correct.
Signature: 

Date: 4/9/13

Thomas C. Choate
Chief Growth Officer
UnitedHealthcare

Tom currently serves as the Chief Growth Officer for UnitedHealthcare's employer and individual business. In this role, he is responsible for national sales strategy and operations across the lines of business and for all distribution relationships, including brokers, consultants, PEOs and direct marketing. Tom has been in this position since January 2012.

In 2005, after holding various positions in the underwriting organization, Tom was named Executive Vice President of Underwriting and Pricing, responsible for all underwriting and pricing activities in the employer and individual markets.

Tom joined UnitedHealthcare in 1998 and was selected to participate in the President's Leadership Development Program. Previously, Tom held underwriting positions with HealthNet and Cigna Healthcare.

Tom received his BS from the University of Connecticut and has completed the Wharton Executive Education Program. He lives in Connecticut with his wife and three children.